Medicare Rx Update: February 13, 2006

Transition must be meaningful … and that takes time… and engagement

The purpose of a transition period is to provide adequate time for beneficiaries to work with their plans, physicians and pharmacists to effectively transition from a non-formulary drug to a drug covered by a plan's formulary. Recognizing that some plans did not have enough time to effectuate an adequate transition while dealing with January implementation issues, Secretary Leavitt extended the formulary transition period, which was implemented through a letter to plans last week (see attachment: Transition Extension 2.pdf).

During the transition process, a physician may determine that a non-formulary drug is medically necessary for the patient. Looking ahead, CMS is working with plans and partners to simplify this process for physicians, pharmacists and beneficiaries. For example, CMS partners have created a model exceptions form to help facilitate this process:
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/ModelCoverageDeterminationRequestForm.pdf

As a reminder, CMS has provided a model pharmacy notice about the formulary exceptions and appeals process that should be posted or given to beneficiaries interested in contacting a Plan about a formulary exception.
http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PharmacyNoticeApproved.zip

Click here for instructions for using the notice:
http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PharmacyNoticeInstructions.pdf

Both physicians and pharmacists need to contact plans directly as part of this process and to resolve other beneficiary issues. To provide better support for physicians and pharmacists, CMS has posted an updated list of Plan contact numbers for both physicians and pharmacists.
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp

… don't close that billing window, yet!

As we are all aware, data translation problems, incorrect information and systems overload associated with Part D implementation caused many pharmacists to delay submission or resubmit claims to Part D plans. Many Plans leave the billing window open for only 30 days. Indeed, some plans began rejecting these claims as too old on February 1. As a result, CMS released a notice to plans requesting that they not implement 30-day billing limits for pharmacy claims submission. Specifically, CMS is asking plans to relax their edits to allow pharmacists to bill Part D plans for claims that are as old as 90 days. This should allow plenty of time to clean up the backlog and any remaining problem claims (see: 02 07 06_30DayBillingLimit.pdf).

Looking forward to a smooth March... Enroll early and not often!

We are doing everything we can to make processes more efficient so plan and pharmacy systems populate with correct beneficiary information for smooth transactions at the pharmacy counter. However, the later in the month a beneficiary enrolls, the more likely it is that they may experience delays in processing when filling a prescription at the beginning of the first month of the effective date of their coverage. This is a reality we face when enrollment ends and coverage begins with no time in between. You can help by telling beneficiaries that the later in the month they wait to enroll; the more likely it is that they may not have adequate information in the pharmacy system to process their prescription smoothly when their coverage becomes effective on March 1. CMS has prepared a tip sheet to assist you in conveying this message to

beneficiaries.
http://www.cms.hhs.gov/Partnerships/Downloads/earlyinmonthtipsheet.pdf

Questions of the Week…

In response to issues raised by pharmacists, this week we issued the following Q&A on co-branding. In addition, this Q&A about the Wellpoint Point-of-Sale process might be helpful for LTC pharmacies:

Q: Can Part D Plans co-brand with non-PDP partners?

A: Yes, as long as certain requirements are met by the plan. Co-branding is a relationship between two or more separate legal entities, one of which is a sponsoring Part D Plan. The sponsoring Part D Plan includes the name(s) or brand of the co-branding entity on its marketing materials. Co-branding arrangements allow a Part D Plan and its co-branding partner(s) to promote enrollment into the Part D Plan.

Co-branding relationships are not intended to convey to beneficiaries that the pharmacy on a member identification card is the beneficiary's only choice of pharmacy. Co-branding Plans are strongly encouraged to make this point clear in materials accompanying the member identification card or on the member identification card itself. Beneficiaries have access to a list of participating pharmacies via each plan's pharmacy directory, which, at a minimum, is required to be provided to enrollees at the time of enrollment and on the plan's website. An enrollee may also use Medicare's Plan Finder or call 1-800-Medicare to determine what pharmacies participate with a specific plan. An enrollee may also call the Plan to ask about contracting pharmacies or speak with a pharmacist to determine if the pharmacy participates with a particular plan, provided the pharmacist complies with the Medicare marketing guidelines.

Co-branding relationships are permitted under the Medicare Marketing Guidelines provided certain requirements are met by the plan. The Marketing Guidelines were subject to public comment before they were finalized for the 2006 plan year. We are currently evaluating our marketing guidelines for 2007 and we will invite further public comment on the rules for co-branding relationships before these rules are finalized for 2007.

Q: How does the LTC pharmacy get Wellpoint to process the Point of Sale claims with appropriate co-payments?

A: LTC pharmacies can call Wellpoint at (800) 662-0210, then press option 1, and follow the directions. When an operator answers, the LTC pharmacy will need to identify itself as a LTC pharmacy working with SNF beneficiaries and Wellpoint will make the appropriate co-payment changes. Remember, this process is only for dually eligible beneficiaries with no Part D coverage, and only institutionalized full benefit dual eligibles may receive $0 co-payments.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-19-16
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February 2, 2006

Memorandum To: Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans

Subject: Extension of Transition Period to March 31

From: Mark McClellan, M.D., Ph.D., Administrator

As a result of our mutual efforts, every day more and more of our Medicare beneficiaries are getting the drugs they need at the right cost from their pharmacies. I know and appreciate how much hard work it has taken to make these critical improvements in beneficiary service.

However, because so many people are moving from Medicaid coverage to Medicare coverage for their prescription drugs on January 1, we recognize, as many of you already have, that some people will come back to the pharmacy for refills without having had the benefit of an appropriate transition to a formulary drug that works very similarly to their current medication or to request an exception.

I know that some of you are already providing a 90-day period to effect a meaningful transition. I also know that some potential problems are being resolved directly at the pharmacy counter with the voluntary agreement of the customer. It is imperative to ensure that every beneficiary, particularly the Medicaid/Medicare dual eligible beneficiaries, have adequate time to learn the new system and do what they need to do so that Part D covered medically necessary medications are available to them. Accordingly, I am calling for a one-time across the board extension of the transition period to March 31 for those individuals who were enrolled in the first few months of the program. This is necessary because of the extraordinary volume of transactions at both plans and pharmacies during the start-up phase of a new program that affected millions of people. For community-based individuals who enroll on March 1 or thereafter, the 30-day transition policy remains in place.

In addition, for those plans that were providing no more than a 60-day transition for long term care individuals, I am calling for a one-time across the board extension of the transition period to March 31 for those individuals who were enrolled in the first few months of the program. For those plans that were already offering a longer transition period of 90-days or more, your current transition plan will stay in place.

An across the board extension will benefit beneficiaries, plans, and providers. It will provide time for us to work with you, pharmacists and providers to assure that straight forward appeals processes are in place, and help assure that you can meet performance requirements. It will reduce the volume of calls from pharmacies to plans, thereby reducing the wait time and abandonment rate on your pharmacy help lines. It will give beneficiaries sufficient time to work with their providers to either change their prescriptions or request an exception. But most importantly, it will help ensure that no beneficiaries go without the drugs they need.

Please reply to CMS by COB Monday, February 6, 2006, with your intention to implement this transition policy. Send your reply to marrietta.mack@cms.hhs.gov. Include in the subject line the following, "90 day transition : <insert organization name(s)>". CMS staff is ready to assist you in any way they can promptly.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR BENEFICIARY CHOICES

MEMORANDUM

TO: All Part D Plan Sponsors

FROM: Gary Bailey, Deputy Director for Plan Policy and Operations

RE: 30 Day Billing Limit for Pharmacists and Beneficiaries

DATE: February 7, 2006

We want to again thank all the Part D plans for their willingness to work with CMS over the past month as we implement the Medicare prescription drug benefits for our beneficiaries. Through your work, we have provided prescription drugs to millions of Medicare beneficiaries.

We are working on various issues that we hope will continue to provide for smooth implementation of the benefit. Over the past week, pharmacists have begun to bill or to resubmit bills to Part D plans for claims that were lacking correct billing information. As they attempt this rebilling, pharmacists are encountering a 30 day billing limit placed by the Part D plan. That is, the Part D plan is again rejecting the drug claim as "too old" because it exceeds the 30 day limit.

There may also be beneficiaries who will need to request reimbursement from the plan for incorrect co-payment amounts or other payments they made that were incorrect.

Because of systems issues being encountered at CMS and at plans, we are requesting that plans not implement 30-day billing limits placed on pharmacists and beneficiaries. Instead, these edits should be relaxed to allow pharmacists to bill Part D plans for claims that are as old as 90 days. In addition, beneficiaries should have 90 days in which to provide documentation to the plan for any incorrect payments they may have made.

If you have any questions about this issue, please contact your account manager.

Thank you for your continued assistance with the implementation of the Part D benefit.